

Terbinafine (Lamisil®), Itraconazole (Sporanox®), Ciclopirox (Penlac®) Prior Authorization Request Form

To be completed and signed by the prescriber.-To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP). Express Scripts is the TMOP contractor for DoD.

Your patient receives their prescription drug benefit from the Department of Defense (DoD). The DoD prescription drug benefit plan requires that we review certain requests for coverage with the prescribing physician. You have prescribed a medication for your patient that requires prior authorization before benefit coverage can be provided. **Before giving the prescription to the patient, please make a copy of this form, complete the following questions and give the completed form, along with the prescription, to the patient. Please instruct the patient to send this completed form, along with the prescription, to Express Scripts for processing.**

If Express-Scripts already has your patient's prescription and has requested that you complete this form, the completed form may be faxed to: (877) 895-1900 (toll-free) or (602) 586-3911 (commercial). A copy of this form and explanations of the underlying clinical rationale and criteria for approval are available at www.pec.ha.osd.mil/PA_Criteria_and_forms.htm.

Drug for which Prior Authorization is requested: ☐ Terbinafine (Lamisil®)
☐ Itraconazole (Sporanox®)
☐ Ciclopirox (Penlac®)

Step 1 Complete patient and physician information (Please print)

1

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
Member #: _____ Phone #: _____
Secure Fax #: _____

Step 2 Why is terbinafine (Lamisil®), itraconazole (Sporanox®), or ciclopirox [Penlac®] being prescribed?

2

- ☐ For treatment of onychomycosis of fingernails – proceed to Step 3.
- ☐ For treatment of onychomycosis of toenails – proceed to Step 3.
- ☐ For treatment/prophylaxis of fungal infection other than onychomycosis – Benefit approved for 1 year.

Step 3 Was the diagnosis of onychomycosis confirmed by a microbiological or histological test [KOH preparation, periodic acid Schiff (PAS) stain, or culture]?

3

Please note: Each course of treatment requires confirmation of fungal infection using one of the above tests.

- ☐ Yes
- For fingernail treatment, benefit coverage approved for 6 weeks for terbinafine or itraconazole, up to 48 weeks for ciclopirox.
 - For toenail treatment, benefit coverage approved for 12 weeks for terbinafine, itraconazole, up to 48 weeks for ciclopirox.
- ☐ No. Benefit coverage not approved.

Step 4 Please sign and date:

4

Prescriber Signature

Date